

Registration District No. **8**

Primary Registration District No. **3006-5-1-2-0**

1. PLACE OF DEATH:

(a) County **Boone**  
(b) City or town **Columbia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Clis Fischel Cancer Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 day**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Macon**  
(c) City or town **Anabel**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Tiller Emma**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, **widow**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **June 7 1867**  
(Month) (Day) (Year)

8. AGE: Years **76** Months **2** Days **13** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Macon Co. Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business \_\_\_\_\_

12. Name **Daniel Mc Kenzie**

13. Birthplace **Wentz**  
(City, town, or county) (State or foreign country)

14. Maiden name **Harriett Waddell**

15. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Patricia**

(b) Address **Anabel, Mo.**

17. (a) **Burial** (b) Date thereof **8-22-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anabel, Mo.**

18. (a) Signature of funeral director **Stephen S. Gooding**

(b) Address **Macon, Mo.**

19. (a) **8-21-43** (b) **E. C. H. Barber**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **20**  
year **1943** hour **2:00** minute **PM** M.

21. I hereby certify that I attended the deceased from **8-19-43**  
19\_\_\_\_ to **8-20-43**, 19\_\_\_\_;  
that I last saw h. **alive** on **8-20-43**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**

Due to **preparation of colon**

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Carcinoma of ascending colon**  
Of operations **2 yrs duration**  
Of autopsy **same**

Duration  
**Several days**  
**Several days**

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **J. V. Ackerman** (M. D. or other) **M.D.**  
Address **Cancer Hospital Columbia Mo.** Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1250

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. *3057*

P. O. Address *Macon, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**